State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE MARY M. MUSHINSKY
EIGHTY-FIFTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 4038
HARTFORD, CT 06106-1591
HOME: (203) 269--8378
CAPITOL: (860) 240-8500
TOLL FREE: 1-800-842-8267
E-mail: Mary.Mushinsky@cga.ct.gov

CO-CHAIR
PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

MEMBER
ENVIRONMENT COMMITTEE
FINANCE REVENUE AND BONDING COMMITTEE

Testimony of Rep. Mary Mushinsky (85th) in Support of the Recommendations of the PRI Committee Report, Hospital Emergency Use and Its Impact on the State Medicaid Budget

Before the Appropriations Committee, Health and Hospitals Subcommittee and Human Services Subcommittee
Tuesday, February 18, 2014 4:00 p.m. in Room 2C

At the request of the Appropriations Committee through the co-chairs, Program Review and Investigations Committee in fall 2013 looked at the use of hospital emergency rooms by Medicaid recipients and the impact of that use on the state Medicaid budget. We are submitting several copies of our Jan. 31, 2014 report to the subcommittee. The report is also available on our website.

There are several key findings that the two subcommittees should take into consideration:

1. Medicaid clients accounted for 36 % of all visits, even though Medicaid recipients make up about 17% of the state's population. Those clients enrolled in HUSKY D had the highest rate of visits to the Emergency Department. Of the 605,506 Medicaid visits, the average cost per visit was $350.
2. Emergency Department (ED) use is extremely varied, with more than half of Medicaid clients not visiting an ED at all during 2012. However, there is a small segment of the Medicaid population who frequently visit the ED: 4,671 clients had 10 visits; 865 enrolees had 20 or more, and 196 had visited at least 5 different hospital ED's in one year.
3. Only about 15 % of ED visits require an inpatient admission, but among Medicaid clients this was even lower: about 7% were admitted.

4. Only about half of all Medicaid clients are linked to a primary care provider; even fewer to a medical home.
5. Intensive case management programs under contract to DSS and DMHAS target individuals with complex medical needs and frequent ED users. Those programs with more face-to-face client interaction, hospital emergency department involvement, ongoing client monitoring, and frequent provider interaction in monitoring a client's progress seem to have better outcomes.

As a result we are recommending the following:

1. Recommend better education of Medicaid clients about more appropriate settings to getting health care (13 recommendations).
2. Improve Medicaid enrollment stability through 12-month continuous eligibility, a more active approach linking clients to primary care providers, and better measurement of network adequacy.
3. Require DSS to implement a demonstration project using telehealth or telemedicine to help clients access specialists.
4. For clients who need intensive case management (ICM), we recommend more client interaction, especially at the Emergency Department. We recommend better coordination of all ICM services and seeking Medicaid reimbursement for ICM services. A successful example is Middlesex Hospital in Middletown. Please note we believe there are substantial savings possible ($2.2 million annually) if we require through existing contracts co-location of intensive case management staff at certain hospitals where Medicaid clients are frequent users of the Emergency Department.
5. We propose the ACEP guidelines for prescribing controlled prescription drugs in the Emergency Department, including a check of the state's prescription monitoring system.

We are happy to meet with your subcommittee and bring our PRI research team to discuss the report's recommendations. Thank you for your attention to this issue.

attachment: Hospital Emergency Department Use and Its Impact on the State Medicaid Budget (Report of PRI Committee, Jan. 23, 2014)